STATE OF VERMONT

HUMAN SERVICES BOARD

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| In re | ) | Fair Hearing No. 15,964 |
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| Appeal of | ) | |
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## INTRODUCTION

The petitioner appeals a decision of the Department of Social Welfare denying coverage for graduated bifocal lenses under the Medicaid program. The issue is whether the petitioner's appeal was timely filed and, if it was, whether the petitioner demonstrated a medical need for such glasses.

## FINDINGS OF FACT

1. The petitioner is a Medicaid recipient who has been prescribed corrective lenses for both reading and long distance vision. He typically has his glasses made-up with bifocal lenses which have a line through them. He began to find those lenses uncomfortable and decided, at the suggestion of his ophthalmologist, to try lenses which have no-line but rather graduate from one strength to the other. However, he was advised by his ophthalmologist that Medicaid usually did not pay for such special lenses.

2. The petitioner called a Medicaid information line to ask if this were so and was told that special lenses could only be paid for with prior approval. He was told he could ask his ophthalmologist to send a letter asking for an exception if he had a medical need for special lenses.

3. The petitioner's ophthalmologist requested such

approval for the special lenses in a letter dated October 29, 1998. The letter asked for "photogray extra lenses in a progressive add (varilux comfort)," and gave no reason other than that the petitioner is "sensitive to light, but not due to a medical condition."

4. That request was denied by the Department on November 19, 1998, because coverage of such lenses was "limited to treatment of medical condition--not covered as a comfort or convenience item." The petitioner did not appeal that denial.

5. Some months later, the petitioner decided to go ahead and authorize his ophthalmologist to make-up the kind of straight-line lenses for which the Department would pay. His ophthalmologist did as he was requested and gave the petitioner the new glasses on March 12, 1999, noting when he dispensed them that the petitioner did not like the "flat-top" segments but "took them anyway." Medicaid paid the doctor for the provision of these glasses.

6. The petitioner noticed as soon as he put the glasses on that he would not be able to use them because the line was too high. He returned to his ophthalmologist on April 2, 1999 and asked him to re-make the lenses. He did re-make the lenses and gave them to the petitioner on April 15, 1999. Still unhappy with his glasses situation, the petitioner appealed the original denial of the graduated lens on April 28, 1999.

7. Subsequently, Medicaid was billed for the re-make of the lenses but refused to pay because the petitioner was not covered under the Medicaid program from April 1 through April 16 due to his failure to make a timely reapplication for benefits. He did receive VHAP coverage after April 15. The $30 bill for the re-make was forwarded to the petitioner on May 20, 1999.[1]

8. After the appeal was filed, the Department contacted the petitioner's ophthalmologist to see if his need for graduated lenses had a medical basis. The doctor responded on June 22, 1999 as follows:

> There is no medical diagnosis that requires a "no-line" bifocal as treatment. [Petitioner's] desire for this type of bifocal stems from his past pair of glasses that broke. Medicaid insurance supplied him with a "flat-top" bifocal that he is not able to adapt to. Any need [petitioner] has for a no-line bifocal is based upon his comfort level with daily living activities or occupational needs. I leave it up to you.

[1] The petitioner raised the issue of non-payment of the reformulated lenses for the first time at the hearing itself. Since the Department was not aware that this was a potential issue in this matter, it was allowed to submit information in writing following the hearing detailing why this amount had not been paid. The petitioner was then given leave to respond to those facts within a week after they were presented to him and to be heard thereon if he desired. The Department provided this information to the petitioner on July 7, 1999. By August 13, 1999, the petitioner had not contested or responded to the alleged facts in any way, although he was reminded in the July 7 letter that he could do so. As the facts in this paragraph were not contested, the hearing officer will take them as true for purposes of this hearing.

## ORDER

The decision of the Department denying payment for the progressive lens and payment for the remake of the lenses is affirmed.

## REASONS

Under Fair Hearing Rules adopted by the Human Services Board effective October 16, 1995, appeals from decisions of the Department of Social Welfare shall not be considered by the Board unless the appeal is presented within 90 days from the date when the grievance arose. Fair Hearing Rule No. 1. In this case, the Department notified the petitioner by letter dated November 19, 1998, that it would not pay for special lenses for him. The petitioner's grievance would have arisen when he received that letter, presumably a day or two after it was mailed. For an appeal in this matter to be timely, it would have to be lodged within 90 days of that time which would have been on or before February 19, 1999. The petitioner did not file his appeal until April 28, 1999, more than two months out of time.

It appears that the petitioner became most dissatisfied with the Department's position after he got his new glasses and found they were unsatisfactory. However, the proper action for the petitioner to have taken at that time was to file a new request for payment of the special lenses with new supporting documentation. He did not reapply but

instead attempted to appeal the old denial. As that appeal was out of time, the Board has no jurisdiction to hear the appeal of that issue and it must be dismissed.

Even if the petitioner's appeal had been timely, the regulations covering eyeglasses and vision care services provide for the coverage of special lenses "when medically necessary and with prior approval." M670.3. The supporting documentation which the petitioner's ophthalmologist provided does not claim that the petitioner has any medical condition which would necessitate graduated lenses.[2] The evidence makes it clear that the request is based on the convenience and comfort of the petitioner, i.e., that he prefers the more expensive, graduated lens. This is not the standard for approval set out above. Without documentation of medical necessity, the petitioner could not have prevailed on this claim, even if it had been timely filed.

Finally, the issue of non-payment for the re-make of the regular lens raised by the petitioner at hearing cannot be resolved in his favor because the only evidence presented was that he was not enrolled in the Medicaid program at the time the service was provided. The petitioner has not rebutted that evidence. If he was not enrolled in the program, he obviously cannot receive coverage payments for medical services rendered to him during his period of non-

[2] At hearing, the petitioner indicated that he is no longer seeking photo-grey lenses but is continuing to seek graduated lenses.

eligibility. As the Department's decisions in this matter are supported by the evidence and regulations, they must be upheld by the Board. 3 V.S.A. ə 3091(d), Fair Hearing Rule No. 17.

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